MDR: M4-02-2274-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $6,998.00 for date of service 10/17/01.

   b. The request was received on 02/21/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. TWCC 62 form
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Surgery: Musculoskeletal System (CPT codes 20000-29999) (Chapter IV of the National Correct Coding Policy Manual for Part B Medicare Carriers) *Version* 6.1.
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/27/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 07/01/02. The response from the insurance carrier was received in the Division on 07/11/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   "Based upon the explanation of benefits dated 12-10-01, a retrospective review of the billed charges has been completed. This review show[sic] two codes were

incorrectly billed, i.e., CPT 22842 and 22630. Enclosed please find HCFA-1500 marked 'Corrected Billing'.

As you will notice, CPT 22842 has been replaced with code 22840 that best represents the procedure performed: ***'L3-L4 instrumentation with 16 MM X 26 MM ray fusion cage under fluoroscopy'.***

Regarding CPT 22630, we have come to the conclusion that interbody fusion was not the primary code in this surgery. The primary code is 63047 (Laminectomy, facetectomy, & foraminotomy). Correction has been made on the enclosed HCFA-1500. The dollar amount allowed ($3,300) for CPT 22630 should be adjusted for CPT 63047 as we seek payment for the primary procedure.

Your findings that the procedure, bone grafting (CPT 20902), and reconstruction of iliac crest is global needs further consideration based upon the above correction."

2. Respondent:

"The following is the carrier's statement with respect to this dispute. It appears the requestor changed its position regarding the billing of its services performed on 10/17/01. '…As you will notice, CPT 22842 has been replaced with code 22840 that best represents the procedure performed: ***L3-L4 instrumentation with the 16 MM X 26 MM ray fusion cage under fluoroscopy'.*** [bold italics, the requestor.] Regarding CPT 22630, we have come to the conclusion that the interbody fusion was not the primary code in this surgery. The primary code is 63047 (Laminectomy, facetectomy, & foraminotomy)…' (Exhibit 1)

This dispute involves the carrier's denial of payment for code 22842, or in the alternative, 22840 for the placement of ray cages. (Carrier) paid $00.00 because the most appropriate code to use is 22899. The requestor improperly coded this procedure as the descriptor for code 22840 clearly reflects.

(Carrier) correctly paid $00.00 for CPT codes 63047 and 63048 because the posterior lumbar interbody fusion cannot be done without performing laminectomies and diskectomies. Medicare clearly understands this because its Correct Coding Initiative indicates that codes 63030 and 63047 are components of code 22630, without exception. 1 (Exhibit 2)

Given the direction from House Bill 2600 and the Commission's intent to use Medicare guidelines in its new Fee Guideline, (Carrier) asserts its reimbursements are correct and cannot authorize any additional payment."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date (s) of service eligible for review is 10/17/01.

2. The denial codes listed on the EOB is "D-DUPLICATE CHARGE. G-ACCORDING TO THE AAOS GLOBAL SERVICE DATA FOR ORTHOPEDIC SURGERY PUBLICATION, THIS PROCEDURE IS AN INTEGRAL PART OF ANOTHER REIMBURSED PROCEDURE. F-N THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING 'ACCURATE CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT'. THE SERVICES PERFORMED ARE NOT REIMBURSABLE AS BILLED."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
10/17/01	22840	$6,600.00	$0.00	F	$2,225.00	MFG SGR (I)(E)(1) CPT descriptor	According to the MFG Surgery Ground Rules CPT code 63047 reflect the highest MAR value, making it the primary procedure. Currently, the Medical Review Division uses the Physicians' Current Procedural Terminology, Fourth Edition, Copyright 1994 by the American Medical Association (CPT) in conjunction with GSDOS dated 1994. Therefore, according to the GSDOS dated 1994, CPT code 22840, is not global to 63047 and cannot be reduced, and shall be listed separately according to MFG SGR (I)(E)(1). Therefore reimbursement **is** recommended in the amount of **$2,225.50**.
10/17/01	63047	$6,200.00	$0.00	G	$3,540.00	MFG GI (VIII)(C) SGR (I)(D)(1)(a)(b) Global Service Data for Orthopaedic Surgery dated 1994 CPT descriptor	According to the MFG Surgery Ground Rules CPT code 63047 reflects the highest MAR value, making it the primary procedure. Currently, the Medical Review Division uses the Physicians' Current Procedural Terminology, Fourth Edition, Copyright 1994 by the American Medical Association (CPT) in conjunction with GSDOS dated 1994. Therefore, according to the GSDOS dated 1994, CPT code 22830, is not global to 63047. Therefore reimbursement **is** recommended in the amount of **$3,540.00**.

10/17/01	63048	$1,000.00	$0.00	G	$708.00	MFG GI (VIII)(C) SGR (I)(D)(1)(a)(b) Global Service Data for Orthopaedic Surgery dated 1994 CPT descriptor	According to the MFG Surgery Ground Rules CPT code 63047 reflects the highest MAR value, making it the primary procedure. Currently, the Medical Review Division uses the Physicians' Current Procedural Terminology, Fourth Edition, Copyright 1994 by the American Medical Association (CPT) in conjunction with GSDOS dated 1994. Therefore, according to the GSDOS dated 1994, CPT code 63048, is not global to 63047 and will be reduced to 50% of the MAR value according to MFG SGR (I)(D)(1)(b). Therefore reimbursement **is** recommended in the amount of **$708.00**.
10/17/01	20902	$1,500.00	$0.00	F	$526.00	MFG SGR (I)(D)(1)(b)(iv) CPT descriptor	Currently, the Medical Review Division uses the Physicians' Current Procedural Terminology, Fourth Edition, Copyright 1994 by the American Medical Association (CPT) in conjunction with GSDOS dated 1994. Therefore, according to the GSDOS dated 1994, CPT code 20902, is not global to 63047 and will be reduced to 50% of the MAR value according to MFG SGR (I)(D)(1)(b)(iv). According to the referenced Rule, "the secondary or subsequent procedures are performed in a remote area, but are related to the primary procedure." Therefore reimbursement **is** recommended in the amount of **$263.00**.
Totals							The Requestor **is** entitled to reimbursement in the amount of **$6,736.50.**

The above Findings and Decision are hereby issued this 30th day of September 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $6,736.50 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 30th day of September 2002.

Carolyn Ollar
Supervisor Medical Dispute
Medical Review Division

CO/cmb